STATEMENT FOR MISCELLANEOUS SERVICES



DO NOT WRITE IN SPACE >

Billing for 1 client served at 2 appointments in 1 day

Sample Interpreter

Dept of Labor and Industries Claims Section PO Box 44269 Olympia WA 98504-4269

Dental Services		Glasses
Medical Equipment/ Prosthetics-Orthotics		Vocational/ Retraining
Transportation	X	Other
Home Health/ Nursing Home Services		

WORKER'S NAM	ЛЕ IN FU	JLL	First			Middle		SSN (II	D on	nly)				Claim	Number	
Doo John A													Y0	Y000000		
Last DOE JOHN A Address						Employer's Name										
114 Foxtail Lane						ABC Employer										
Any City State ZIP WA 00000							Reimburse injured worker Yes No					If yes.	If yes, receipt required			
Date of Injury Name of referring physician or other source						Referring physician provider number / NPI							oo, roooipt roquirou			
DD/MM/YY James Jones, MD DIAGNOSIS OR NATURE OF ILLNESS OR INJURY For glasses, advise if old Rx was						000000/000000 REFUND CERTIFICATION										
(use ICD-9-CM) Designate left or right when applicable. Available 1.				ble?	I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses											
2.						ospitalization dates for inpati	incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.									
3. Service									CLAIMANT'S SIGNATURE:							
4					ed/											
5. FROM DATE	Р	PROC	MOD	Describe		dures, medical services, or De		Но	lome Nursing Glasses			1	Charges	Unit	TO DATE	
OF SERVICE	O S	CODE	CODE	supplies	s furnished. Attach lab reports, ndings and any special services	ed. Attach lab reports,	Tooth Number			Hourly	NEW RX				OF SERVICE	
								hrs/day	у	Day rate	OD OS	OD O	S			
11/1/08	XX	9989N	1	Indiv	ridua	I Interpretation				HARGES:				\$xx.xx	00	11/1/08
11/1/08	XX	9986N	1	Mileage					narge your usual and ustomary fees			L	\$xx.xx		00	11/1/08
11/1/08	XX	9989N	1	Indiv	ridua	I Interpretation		Г					Ш	\$xx.xx	00	11/1/08
11/1/08	XX	9986N	1	Milea	age			UNIT: Individual Interpretation:			\$xx_xx	00	11/1/08			
									L	Jnit = Nun	nber of mi	inutes			>	
									Mileage:							
								Unit = Number of miles								
Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as Interpretar's Name						Provider number NPI Interpreters XXXXXXXX			XXXX	Taxonomy XXXXXX						
charged in the foregoing bill is a true and correct charge against				Provider #				,,,,,,,,	7000000							
part of the same has been paid. Address Interpreter's Address													Total Charge \$XX.XX			
Signature: Bill date: City							State ZIP + 4						Phone Number			
Interpreter's signature MM/DD/YY Any City						WA 00000-0000							555-	555-5555		
Remarks: Federal tax ID XXXXXXXXXXXXXX X EIN SSN									Your Patient's Account Number							
*Place of Service (POS) codes on back																
F245-072-000 statement for misc services 8-07									Referra	I ID						